MEDICARE ANNUAL REPORT TO CONGRESS

Fiscal Year 1991

U.S. Department of Health and Human Services
Health Care Financing Administration

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INTRODUCTION

Medicare is a Federal health insurance program for people age 65 or older, certain younger disabled people, and people of any age with permanent kidney failure. The program is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (DHHS). The Social Security Administration (SSA) provides information to the public about the program and handles enrollment.

Enacted into law in July 1965 and inaugurated a year later, Medicare has two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Hospital Insurance helps pay for medically necessary care provided by a Medicare-approved hospital, skilled nursing facility, home health agency, or hospice program. Medical Insurance helps pay for medically necessary physician services, outpatient hospital services, certain home health care services, durable medical equipment, and various medical services and supplies not covered by Hospital Insurance.

Payments for services and supplies provided to Medicare beneficiaries are generally made through private insurance organizations under contract with the Federal government. Hospital Insurance claims are handled by Medicare "fiscal intermediaries" (FIs), and Medical Insurance claims by Medicare "carriers." The government also contracts with prepaid health care plans, such as health care maintenance organizations (HMOs), to provide Medicare-covered services to beneficiaries who voluntarily enroll in a plan.

To administer the Medicare program and the Federal portion of the Medicaid program during fiscal year (FY) 1991, HCFA had 4,250 employees working at its central office in Baltimore, MD, executive offices in Washington, D.C., and 10 regional offices. Their varied assignments included policy development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, health care quality standards enforcement, and public information functions. These activities were overseen by the Administrator, who is assisted by a deputy administrator, and associate administrators for management, operations, program development, and communications. The regional offices, which are managed by regional administrators, are located in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, Seattle, and San Francisco.

ABBREVIATIONS AND ACRONYMS

AAPCC	Adjusted average per capita cost
CMP	Competitive medical plan
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoPs	Conditions of participation
CPEP	Contractor performance evaluation program
CY	Calendar year
DHHS	U.S. Department of Health and Human Services
DME	Durable medical equipment
DRG	Diagnosis related group
EOMB	Explanation of Medicare benefits
ESRD	End-stage renal disease
FFP	Federal financial participation
FI	Fiscal intermediary
FY	Fiscal year
HCFA	Health Care Financing Administration
HCPP	Health care prepayment plan
HI	Hospital insurance (Medicare Part A)
HMO	Health maintenance organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LSC	Life Safety Code
MR	Medical review
MSP	Medicare Secondary Payer Program
NTIS	National Technical Information Services
OBRA	Omnibus Budget Reconciliation Act
OPA	Office of Public Affairs
OPHCOO	Office of Prepaid Health Care Operations and Oversight
ORD	Office of Research and Demonstrations
P.L.	Public law
PPS	Prospective payment system
PRO	Peer review organization
SAs	State agencies
SHMO	Social health maintenance organization
SMI	Supplementary Medical Insurance (Medicare Part B)
SNF	Skilled nursing facility
SSA	Social Security Administration
SOW	Scope of work
TEFRA	Tax Equity and Fiscal Responsibility Act
UPIN	Unique physician indentifer number

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EXECUTIVE SUMMARY

Beneficiaries

During fiscal year (FY) 1991, the number of Medicare beneficiaries increased by approximately 667,000, from 34.2 million to 34.9 million. Of the total number of beneficiaries, 34.2 million were residents of the United States, 445,000 lived in U.S. commonwealths and territories, and 272,000 resided in other countries. Approximately 95 percent of the Medicare beneficiaries residing in the United States, 66 percent of the those residing in U.S. commonwealths and territories, and 15 percent of the those residing in foreign countries were enrolled in both Medicare Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B).

Benefit Payments

Medicare benefit payments totaled about $113.9 billion in FY 1991, or 6.3 percent more than the benefit outlays for the previous fiscal year. Benefits paid under Part A amounted to $68.4 billion, while those paid under Part B totaled $45.5 billion. Inpatient hospital care accounted for $60.7 billion, or nearly 90 percent of Part A spending. Physician services, at more than $31 billion, accounted for more than 68 percent of Part B spending during the fiscal year.

Program Funding

In FY 1991, about 89 percent of the financing for Medicare Part A was derived from employment taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues and other sources. Part B was financed by three sources: (1) premium payments from enrollees (24.5 percent); (2) contributions from general revenues (72 percent); and (3) interest on balances in the SMI Trust Fund (3.4 percent). The Part B monthly premium was $29.90 in calendar year (CY) 1991.

Participating Physicians and Medical Suppliers

Nearly 48 percent of physicians (360,765) and about 23 percent of medical suppliers (28,667) serving Medicare beneficiaries signed participation agreements with the Health Care Financing Administration (HCFA) for CY 1991. Physicians and suppliers may choose each year to participate in Medicare and to accept assignment on all Medicare claims. Participating physicians and suppliers agree to accept Medicare approved

amounts as payment in full for their services regardless of the actual charges.

Quality of Care Monitored

Peer Review Organizations (PROs) under the aegis of HCFA concentrated during the fiscal year on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the 53 PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day- and cost-outlier cases. PROs identified 330 physicians and 122 providers with potential sanctionable violations during the fiscal year and sent 116 notices informing them of the possibility of being sanctioned. Sanctions imposed by the Office of Inspector General of the Department of Health and Human Services (DHHS) resulted in 10 physicians being excluded from the Medicare program for varying periods of time. Additionally, two physicians retired prior to the imposition of a sanction.

Prepayment Plan Option Emphasized

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by promoting prepayment health plans as an option for beneficiaries to consider in determining how they would receive Medicare-covered services. At the end of the fiscal year, more than 2.1 million Medicare beneficiaries were enrolled in 169 prepaid health plans that had either a contract or agreement with HCFA. That was a 7.5 percent increase over the enrollment figure for FY 1990.

Medicare Payment Safeguards

Various oversight activities undertaken by HCFA and the Medicare contractors during the fiscal year to protect the Medicare Trust Funds resulted in savings to the program of more than $5.7 billion. This activity has been cost-effective, with FY 1991 program savings of more than $16 for each administrative dollar expended.

Contractor Performance Evaluation Program

HCFA's Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. During FY 1991,

66 standards were applied to measuring the performance of fiscal intermediaries (FIs) and 67 standards were applied to carriers. Only two FIs failed to pass the CPEP while seven carriers were found to have deficiencies in one or more functional areas. Those falling short of the standards were required to implement plans to improve their performances.

Validation Surveys of Hospitals

The purpose of the Medicare validation program is to determine the effectiveness of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare conditions of participation (CoPs). Each year a statistical sample of the approximately 5,200 Joint Commission accredited hospitals is selected for validation surveys. Under contract with the Secretary of DHHS, Medicare State survey agencies (SAs) conducted 230 sample validation surveys during CY 1991 and investigated 1,057 complaints which led to 150 full allegation surveys. Sixteen percent of the hospitals surveyed as the result of complaints were not in compliance with one or more of the CoPs.

CHAPTER I

THE MEDICARE POPULATION AND BENEFITS

INTRODUCTION

Medicare enrollment increased 1.9 percent in FY 1991 from 34.2 million to 34.9 million, and benefit outlays rose 6.3 percent from $107.2 billion to $113.9 billion. One out of every seven Americans had some Medicare coverage during the fiscal year, which means that the Medicare program covered about 13.5 percent of the United States resident population of 252.7 million.

MEDICARE BENEFICIARIES

Approximately 667,000 individuals were added to the Medicare rolls during the year. Some 536,500 of the new enrollees were 65 years of age or older, bringing to 31.5 million the number of elderly beneficiaries, and 130,500 were younger disabled persons, increasing the number of disabled beneficiaries to 3.4 million. Included among the disabled were 69,000 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the approximately 34.9 million beneficiaries, 34.2 million were residents of one of the 50 States or the District of Columbia, 437,000 resided in Puerto Rico, 7,600 in the Virgin Islands, 890 in Guam, and 260 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 272,000 resided in foreign countries. Ninety-five percent of the Medicare population in the 50 states and the District of Columbia, 66 percent of the beneficiaries in U.S. commonwealths and territories, and 15 percent of the beneficiaries in foreign countries were enrolled in both Medicare Part A and Part B.

Women accounted for 57.7 percent of the total Medicare population, 59.8 percent of the beneficiaries 65 years of age and older, and 37.6 percent of the disabled enrollees. The percentage of disabled who are men, while down slightly in FY 1991 to 62.4, has remained relatively constant since FY 1980 as has the percentage of aged who are men. Minorities represent a growing proportion of the Medicare population. In FY 1991, 4 million Medicare enrollees were other than white. This represented 11.5 percent of the Medicare population, the same as FY 1990 and an increase of 1.6 percent over FY 1980 when 9.9 percent of beneficiaries were non-white. While non-whites made up only 10.3 percent of aged beneficiaries, 22.8 percent of the disabled beneficiaries were other than white, an increase of less than 1 percent over the figure for the previous fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, about 1.7 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. In FY 1991, 3.4 million, or 10.8 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intense health care services than do younger beneficiaries.

BENEFIT EXPENDITURES

Medicare benefit payments for FY 1991 totaled about $113.9 billion, or 6.3 percent more than for the previous fiscal year. Benefits paid under Medicare Hospital Insurance (Part A) increased 4.2 percent, while those paid under Medicare Supplementary Medical Insurance (Part B) increased 9.7 percent. Benefit payments for FY 1991 were broken down as follows:

* Hospital Insurance (Part A)--$68.4 billion
* Supplementary Medical Insurance (Part B)--$45.5 billion

Part A spending was divided among its components as follows:

Benefit	FY 1990	FY 1991	% Change
	(Dollars in Millions)		
Inpatient Hospital	$58,948	$60,735	3.0
Skilled Nursing Facility	2,781	2,460	-11.5
Home Health	3,644	4,788	31.4
Hospice	320	465	45.3
Total	$65,693	$68,448	4.2

Of all purchases, hospital care, at $60.7 billion, accounted for the largest portion of Medicare spending during the fiscal year. About 55 percent of Medicare's total benefit expenditures and nearly 90 percent of Part A outlays went for inpatient hospitalization. Medicare beneficiaries are entitled to 90 days of inpatient hospital care in each benefit period. A benefit period begins the first day a beneficiary receives Medicare-covered services in a hospital. It ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary can have. In addition to the 90 days of inpatient hospital care, a beneficiary also has 60 "lifetime reserve days" which can be used whenever more than 90 days of hospitalization are required. Once used, lifetime reserve days are not renewed.

Medicare paid $2.5 billion for skilled nursing facility (SNF) services in FY 1991, or about 11.5 percent less than in the last fiscal year. The cost of SNF services accounted for nearly 4 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of SNF care during a benefit period, provided the SNF admission follows an inpatient hospital stay of at least three consecutive days and certain other conditions are met.

The $4.8 billion spent on home health services during the fiscal year was 31.4 percent higher than home health outlays in FY 1990. However, it accounted for only 7 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy and speech therapy. The patient must be homebound to qualify for the Medicare home health benefit.

For the fourth consecutive fiscal year, the greatest percentage increase in any single category of Medicare spending was for hospice care, which increased 45.3 percent, from $320 million in FY 1990 to $465 million. However, hospice care accounts for less than 1 percent of Part A benefit payments. The rise was primarily due to the growing popularity of hospice care, which accounted for $4 million in Medicare spending when it was introduced as a benefit in 1984. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

SUPPLEMENTARY MEDICAL INSURANCE

Part B, which, at $45.5 billion, was 9.7 percent higher than in FY 1990, was broken down as follows:

Benefit	FY 1990	FY 1991	% Change
	(Dollars in Millions)		
Physicians	$28,957	$31,102	7.4
Outpatient Services	8,343	9,219	10.5
Group Practice	2,648	3,410	28.8
Independent Laboratory	1,440	1,692	17.5
Home Health	92	72	-21.7
Total	$41,480	$45,494	9.7

The $31 billion spent for physician services was 7.4 percent more than the FY 1990 outlay and represented nearly 68.4 percent of Part B spending for the fiscal year. Part B generally pays 80 percent of Medicare-approved charges for medical services

after the beneficiary pays the first $100 in approved charges each calendar year. Medicare spending for outpatient services increased from $8.3 billion in FY 1990 to $9.2 billion. Outpatient services provided by hospitals are covered under Part B.

The 28.8 percent increase in outlays for group practice plans, rising from $2.6 billion to $3.4 billion, reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). This category of expenditures is only 7.5 percent of total Part B expenditures. There was a 21.7 percent decrease in home health benefit outlays from $92 million to $72 million. This is relatively insignificant as most home health care is covered by Medicare Part A. Climbing significantly during the fiscal year was the percentage of Part B spending for independent laboratory services, jumping 17.5 percent from $1.4 billion in FY 1990 to $1.7 billion.

PROVIDERS

The number of participating hospitals decreased from 6,520 in FY 1990 to 6,487 in FY 1991. During the same period, the number of short-stay hospitals slipped from 5,549 to 5,480 and the number of long-stay hospitals increased from 297 to 300. At the same time, the number of psychiatric hospitals increased from 674 to 707.

There were 315 discharges per 1,000 beneficiaries in FY 1991 compared with 314 discharges per 1,000 beneficiaries for the previous 12-month period. Moreover, the 2,758 days of care per 1,000 enrollees in FY 1991 were 53 fewer than in FY 1990. The average length of a hospital stay was 8.7 days, down from 8.9 days in FY 1990.

During the fiscal year, the number of SNFs rose from 8,937 to 9,674 and the number of SNF beds increased by about 58,000 to 567,000. The number of home health agencies increased during the reporting period from 5,730 to 5,826.

Other providers participating in Medicare during the fiscal year included 4,926 independent laboratories, 2,130 end-stage renal disease (ESRD) facilities, 193 comprehensive outpatient rehabilitation facilities, 1,335 ambulatory surgical centers and 1,057 hospices.

PROGRAM FUNDING

Under the Social Security Act, the Federal Hospital Insurance (Part A) and the Federal Supplementary Medical Insurance (Part B) Trust Funds are administered by two boards of trustees, each with the same five members. Three members serve in an *ex officio*

capacity: The Secretary of Treasury, who by law serves as managing trustee of both funds, the Secretary of Labor, and the Secretary of Health and Human Services. Two public members are nominated by the President for four-year terms subject to confirmation by the Senate. The Administrator of HCFA serves as secretary of both boards.

The primary source of Part A financing (about 89 percent) was derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B was financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues, and (3) interest on trust fund reserves. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act was set at 25 percent of program costs. In FY 1991, beneficiary premiums covered 24.5 percent, and government contributions 72 percent, of the cost of Part B. Interest on trust fund reserves covered the balance. The monthly Part B premium was $29.90 in CY 1991.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the 1991 annual reports of the trustees of the respective funds.

CHAPTER II

REPORT TO CONGRESS ON THE UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION PROGRAM

BACKGROUND

Section 1161 of the Social Security Act (the Act) requires that HCFA give to Congress a full and complete annual report on the administration, impact, and cost of the Utilization and Quality Control Peer Review Organization (PRO) program. This report includes the following items mandated by section 1161 of the Act: (1) the methods of reimbursement for PRO contracts, (2) the number of penalties and sanctions imposed, (3) total Federal expenditures, (4) statistics on PROs participating in the program, (5) the institutions/physicians/beneficiaries subject to PRO review, and (6) criteria for review.

PROs are charged by law to ensure that services rendered to Medicare beneficiaries meet professionally recognized standards of care and are medically necessary and provided in the most appropriate setting (e.g., acute care hospital vs. skilled nursing facility (SNF) or a lesser level of care). Most PRO review is done retrospectively, that is, after the patient has been discharged from the hospital, ambulatory surgical center, or other setting. In this case, after the beneficiary is discharged from the hospital and payment is made to the hospital, paid-bill data are sent by the fiscal intermediary to the PRO. The PRO selects a sample for review and requests the relevant medical records from the hospital.

First level PRO reviewers, primarily nurses, use criteria for review which are developed by local practicing physicians to approve payment for cases which clearly meet acceptable standards. They refer questionable cases to PRO physician reviewers. If the physician reviewer determines that there is a potential utilization or quality problem, the PRO will offer the physician/provider an opportunity to discuss the case and submit additional information, if any is available.

If the PRO physician reviewer determines that the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. It should be noted that only the PRO physician reviewer may deny a case, and denials may be made only after the physician/provider has been given an opportunity to discuss the case with the PRO. If, after the discussion, the PRO physician confirms a problem, the PRO will initiate corrective action.

METHODS OF REIMBURSEMENT FOR PRO CONTRACTS

HCFA has determined that cost-plus-fixed-fee contracts are better suited to the specific demands of PRO contracting than variable fixed-fee contracts. The individual PRO contractors face constant changes in response to legislative, regulatory and policy changes, as well as changes in local review requirements. Each variable fixed-fee contract constantly was being modified to reflect these changes. Accordingly, as the current contracts expire, HCFA will replace them with cost-plus-fixed-fee contracts. Thus, 52 of the 53 PROs had variable, fixed-price contracts. The variable contract has a fixed-price for the accomplishment of a specified task or product, but varies with the number of such items produced. For these contracts, HCFA paid a fixed negotiated amount each month for a PRO's administrative costs, which included the cost of overhead and other nonreview activities, and a separate reimbursement amount for each individual type of completed review (i.e., simple, complex, and ambulatory). The total amount HCFA paid the PROs under these contracts was based on the number of completed reviews they performed in each category, with an upper limit specified in the contract plus the fixed monthly amount. HCFA also paid the PROs a pass-through cost (photocopy and postage expenses for medical records requested by PROs for review) and for the cost of pilot studies and developing sanction cases. The other PRO (Hawaii) was paid under a cost reimbursement contract with a limit on the total expenditures allowed.

PENALTIES AND SANCTIONS

During FY 1991, the PROs identified 330 physicians and 122 providers with potential sanctionable violations under section 1156 of the Act and sent 116 notices informing them of the possibility of being sanctioned. In FY 1991, the Office of Inspector General imposed 12 sanctions based on PRO recommendations. Of the 12 sanctions, 10 physicians were excluded from the Medicare program for varying periods of time, and two physicians retired prior to imposition of a sanction.

TOTAL FEDERAL EXPENDITURES

A total of $272.3 million was expended in FY 1991 under title XI for PRO reviews of Medicare services. An additional $1.9 million was expended for pilot studies. Under title XIX of the Act, States may (at their option) contract with PROs to review Medicaid services. If a State contracts with a PRO, the State receives Federal financial participation (FFP) funding at 75 percent of the cost of a review. In FY 1991, 36 PROs had contracts to review Medicaid services at a cost to the states of $37,319,449. FFP expenditures for the reviews totaled $27,989,586 (Table 1). Total Federal expenditures for FY 1991 were $302.2 million.

STATISTICS ON PROs PARTICIPATING IN THE PROGRAM

In FY 1991, all 53 PROs were operating under the third scope of work (SOW) with 3-year contracts. There is one PRO in each of the 50 States, District of Columbia, Puerto Rico, and the Virgin Islands).[1] Of the 53 PRO areas, the contracts for 11 areas are held by a PRO located in another State, with medical review activities performed by physicians practicing in the particular State. (For example, the Rhode Island PRO has the contract for the State of Maine and utilizes physicians practicing in Maine.)

INSTITUTIONS/PHYSICIANS/BENEFICIARIES SUBJECT TO PRO REVIEW

In FY 1991, a sample of Medicare admissions in 5,471 acute and 1,037 specialty hospitals were reviewed for utilization and quality by PROs. In addition, PROs performed utilization and quality review of ambulatory surgery performed in ambulatory surgical centers (1,374) and hospital outpatient areas (approximately 5,471). PROs also performed:

- Quality reviews, on a sample basis, of SNFs (9,881) and home health agencies (5,920);
- Quality reviews of services rendered to Medicare enrollees of risk-based HMOs/CMPs;
- Preadmission/preprocedure reviews of all cases that included any of 10 procedures identified as requiring prior authorization; and
- Reviews of care provided to beneficiaries who filed quality-of-care complaints.

The PROs completed 4,869,982 reviews in FY 1991. They denied 2.2 percent of the cases reviewed retrospectively and about 0.2 percent of the cases requiring preadmission or preprocedure authorization. There were more than 1,300,952 cases that failed one or more generic quality screens. Of these, 40,002 were confirmed as quality problems.

Although every physician who treats hospitalized Medicare beneficiaries has cases that are subject to review, PROs did not specifically review physician services rendered in the office setting during FY 1991.

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[1] For the third contract cycle, the PRO contracts for Hawaii and the PRO area of American Samoa/Guam and the Commonwealth of the Northern Mariana Islands were combined into one contracting area.

Table 1

PROs WITH CONTRACTS TO REVIEW MEDICAID SERVICES

State	Total Amount	FFP Amount	State Expenditure
Alaska	288,229	216,172	72,057
Arizona	199,466	149,599	49,867
Arkansas	1,061,822	796,366	265,456
Colorado	2,753,185	2,064,889	688,296
Delaware	151,259	113,444	37,815
District of Columbia	377,658	283,243	94,415
Florida	499,919	374,939	124,980
Georgia	2,142,857	1,607,143	535,714
Idaho	432,417	324,313	108,104
Illinois	2,379,450	1,784,588	594,862
Indiana	2,530	1,897	633
Iowa	2,933,028	2,199,771	733,257
Kansas	1,318,008	988,506	329,502
Maryland	2,600,357	1,950,268	650,089
Michigan	723,545	542,659	180,886
Mississippi	1,585,106	1,188,829	396,277
Montana	300,053	225,040	75,013
Nebraska	763,381	572,536	190,845
Nevada	556,005	417,004	139,001
New Hampshire	186,042	139,531	46,511
New Mexico	856,389	642,292	214,097
New York	7,287,743	5,465,807	1,821,936
North Carolina	505,881	379,411	126,470
North Dakota	186,981	140,236	46,745
Ohio[1]	2,500,000	1,875,000	625,000
Oklahoma	124,420	93,315	31,105
Oregon	118,698	89,023	29,675
Puerto Rico	177,006	132,754	44,252
South Carolina	357,305	267,979	89,326
South Dakota	131,150	98,363	32,787
Tennessee	1,561,247	1,170,935	390,312
Vermont	120,579	90,434	30,145
Washington	158,464	118,848	39,616
West Virginia	745,729	559,297	186,432
Wisconsin	1,127,220	845,415	281,805
Wyoming	106,320	79,740	26,580
Total	37,319,449	27,989,586	9,329,863

[1]The Ohio PRO performs review of Medicaid services for the State of Kentucky.

CRITERIA FOR REVIEW

The PROs must develop review criteria which reflect local standards of medical practice in their areas and these criteria must be accepted by HCFA. Review criteria contain the generally recognized reasons which would justify a patient's admission to a hospital or the need for a surgical procedure. The criteria are used by first level PRO reviewers to determine whether Medicare approval can be given. Cases which fail to meet the criteria are referred to PRO physicians, who are actively practicing physicians in the PRO area. The physician reviewers make their determinations regarding the necessity, appropriateness, and quality of care for each questionable case primarily on the basis of their own knowledge, experience, and training and on the basis of discussions with the attending physicians. PRO denials are never based on criteria alone.

In addition, all PROs apply discharge screens and the generic quality screens to all cases retrospectively reviewed under their contracts. The generic quality screens are specific to the type of setting the PRO is reviewing and are indicators used by nonphysician reviewers to identify cases of possible poor quality care. Any case that fails one or more of the screens and is a potential quality problem is further evaluated by PRO physicians who determine whether the care met professionally recognized standards of quality. These determinations are made on a case-by-case basis using the patient's medical record and any additional information available.

CHAPTER III

ENCOURAGING COMPETITION AND CHOICE

INTRODUCTION

HCFA made significant advances during FY 1991 in providing Medicare beneficiaries with an alternative to traditional fee-for-service Medicare through contracts with HMOs and CMPs. As of September 1991, the Agency had contracts with 169 prepaid organizations with an aggregate enrollment of more than 2.1 million Medicare beneficiaries, an increase of 7.5 percent over FY 1990.

Enrollment in prepaid plans with Medicare risk-based contracts reached more than 1.3 million, an increase of nearly 11 percent during the fiscal year. At the same time, enrollment in the cost-based plans was 136,225, while another 617,209 Medicare beneficiaries were enrolled in health care prepayment plans (HCPPs) that had agreements with HCFA during the year. Another 17,537 beneficiaries were enrolled in four prepaid plans with other types of arrangements with HCFA. Total payments to prepaid organization with Medicare contracts for FY 1991 amounted to nearly $5.9 billion.

Following is a breakdown of prepaid organizations with Medicare contracts as of the end of FY 1991:

Type of Contract	Number of Plans	Enrollees
Total prepaid contracts	169	2,116,721
Risk	90	1,345,750
Cost	25	136,225
Other (Social HMOs)	4	17,537
Health Care Prepayment Plans	50	617,209

During the fiscal year, HCFA approved nine new risk contracts, three new HCPP agreements, and six service area expansions. At the same time, three risk-based contracts were not renewed, and the service areas covered by two other contracts were reduced. In addition, eight HMOs/CMPs converted part or all of their risk-based contracts to another type of managed care arrangement. Reasons given by plans for not renewing their contracts were: an inadequate adjusted average per capita cost (AAPCC), and reviews performed by PROs. In response, HCFA and the HMO industry representatives started developing a number of proposals regarding PRO reviews and the AAPCC payment methodology.

LEGISLATIVE ACTIVITY

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which was signed into law November 5, 1990, contained numerous provisions affecting prepaid organizations with Medicare contracts. To ensure the organizations' awareness of OBRA 90, HCFA sent a notice summarizing the pertinent provisions to each of them. They also were provided with updates of the Medicare HMO/CMP Manual stating these provisions. These provisions included:

- **Part A Enrollment-**A special Part A enrollment was authorized for beneficiaries while they are enrolled in an HMO or up to eight months after they disenroll from the HMO. This applies to Medicare beneficiaries enrolled in an HMO any time after May, 1990.

- **Physician Incentive Payments-**HMOs are prohibited from making incentive payments to physicians as an inducement to limit medically necessary services for an identifiable patient. Incentive arrangements that place a physician or group at "substantial" financial risk for services that they do not provide are also prohibited, unless the organization meets minimum criteria (including stop-loss protection, beneficiary surveys, disclosure to the Secretary). Penalties include civil money penalties of $25,000 for each determination and/or suspended enrollment. Effective for contract years beginning on or after January 1, 1992.

- **Payments for Services Furnished by Non-Contract Physicians-**Extends to all physicians services and renal dialysis services, the provision that limits what non-contract providers can charge HMOs for out-of-plan care to what Medicare would otherwise have paid. Effective January 1, 1991.

- **Retroactive Payment Adjustments-**Permits payments to risk HMOs to be retroactively adjusted to reflect enrollments in the HMO through an employer health plan that occurred up to 90 days earlier if the enrollee received the lock-in notice required under section 1876(c)(3)(E) at the time of enrollment. Effective January 1, 1991.

- **Chiropractic Study-**The Secretary is required to study the provision of chiropractic services in HMOs and to submit a report to Congress.

- **Patient Participation in Health Care Decisions-**Requires HMOs and CMPs to maintain written policies and

provide written information at the time of enrollment on "advance directives" (e.g. living wills or power of attorney). Effective December 1, 1991.

• **Extend SHMOs**-The Social HMO demonstrations were extended and expanded.

FY 1991 REGULATIONS AFFECTING PREPAID PLANS

The following regulations impacting Medicare-contracting prepaid health organization were published by HCFA in the Federal Register during FY 1991:

o A proposed rule to broaden the Secretary's authority to impose intermediate sanctions and civil monetary penalties on HMOs and other prepaid health plans contracting under the Medicare or Medicaid programs that (1) substantially fail to provide an enrolled individual with required medically necessary items and services; (2) engage in certain marketing, enrollment, reporting, or claims payment abuses; or (3) in the case of Medicare, employ or contract with, either directly or indirectly, an individual or entity excluded from participation in Medicare. (Office of the Inspector General; proposed rule published July 22, 1991).

o A final rule to revise Medicare requirements relating to HMOs and CMPs. It eliminates the requirement that an organization enroll two new Medicare beneficiaries for each present Medicare enrollee converted from a cost to a risk contract; expands the amount and type of information which an organization must provide to enrollees; and requires annual notice of enrollees' rights under the plan. The rule also authorizes HCFA to terminate a contract with an organization for noncompliance with the composition of enrollment standard requiring that no more than 50 percent of an organization's membership be comprised of Medicare or Medicaid enrollees and authorizes sanctions when an organization fails to comply with the 50/50 rule or any waiver or exception to that rule. (Published September 13, 1991).

o A notice designating the 15 states authorized to approve Medicare SELECT policies for sale as authorized by OBRA 1990. Medicare SELECT policies are Medigap (Medicare supplement) policies that provide less that full benefits when the Medicare beneficiary uses a non-network provider or physician for non-emergency services. (Published September 21, 1991).

HCFA REORGANIZATION

HCFA reorganized responsibilities for coordinated care activities within the Agency in March 1991. The Office of Prepaid Health Care was replaced by two new offices within HCFA, the Office of Coordinated Care Policy and Planning and the Office of Prepaid Health Care Operations and Oversight. The creation of these two new offices was designed to strengthen the policy, planning, evaluation, oversight and promotion of coordinated care activities under Medicare. This updates HCFA's organizational structure to reflect the changing nature of coordinated care initiatives within the Medicare program and the private sector, as well as placing HMO/CMP operational responsibilities under the same administrative control as Medicare fee-for-service operations (including regional offices) and quality review program.

- The Office of Prepaid Health Care Operations and Oversight (OPHCOO) administers operational and payment responsibilities of the Medicare managed care program (established under title XVIII of the Social Security Act) as well as administers operational responsibilities for the Federal HMO qualification program (established under title XIII of the Public Health Service Act).

- Shortly after OPHCOO was created it became evident that OPHCOO could strengthen its management capabilities in several critical areas by restructuring and better realigning responsibilities including delegating of key responsibilities within contract application review and ongoing monitoring to the regional offices. This improved OPHCOO's functional responsiveness and efficiency.

- The Office of Coordinated Care Policy and Planning was established to provide a focus within HCFA for developing coordinated care policy for Medicare contracts with HMOs and CMPs as well as promote the coordinated care concept, evaluate various aspects of Medicare's alternative health care delivery systems, and perform strategic planning.

CHAPTER IV

EFFICIENT OPERATION OF MEDICARE

INTRODUCTION

Medicare contractors fulfill the Federal Government's responsibility of paying Medicare beneficiaries and providers of services in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries (FIs) pay providers of services under Part A of the Medicare program, primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding the medicare Trust Funds against payment for services that are not medically necessary. Carriers adjudicate claims and make payments to beneficiaries and providers of services under Part B of the Medicare program, primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining Medicare's payment amounts for medically necessary covered services, and computing and recovering overpayments in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns that deviate from medically accepted norms and report such deviations to the appropriate professional groups.

A variety of program responsibilities were carried out by HCFA during the fiscal year, including contracting with 82 carriers and FIs, preparing budget statements, and setting standards for Medicare contractors and monitoring their performance. The Agency also established procedures and instructions for all aspects of claims processing and bill payment, and implementing legislative changes. In overseeing contractor payment safeguard activities, HCFA developed a system for identifying employers and insurers responsible for making primary payments for medical costs under the Medicare as Secondary Payer (MSP) provisions, performed intermediary and carrier medical reviews, and audited provider cost reports and overpayment collections.

During FY 1991, contractor administrative costs for processing 592 million claims and related activities totaled $1.45 billion. Contractor budgets have become increasingly tighter in recent years as the volume of claims has soared 47 percent since FY 1987 while contractor budgets have increased 35 percent. The real (after inflation) percentage growth in the contractor budget was even less.

SEARCH FOR PROGRAM EFFICIENCIES

A comprehensive package of legislative and administrative actions was developed to reduce contractor operating costs. The plan emphasized the targeting of budgetary pressure on high-cost contractors, the promotion of a total electronic processing environment and a reduction in the number of appeals considered costly to process. (Table 1, appearing on page 3, provides an overview of contractor monitoring activities from FY 1987 through FY 1991. Table 2, appearing on page 4, presents a detailed breakdown of FY 1991 contractor spending by functional category.)

SAFEGUARDING THE TRUST FUNDS

Despite severe budgetary constraints, HCFA and the Medicare contractors undertook many activities to safeguard the Trust Funds against inappropriate expenditures in FY 1991. Savings of over $5.7 billion were achieved, which resulted in a rate of return of more than $16 for each administrative dollar spent on payment safeguards (See Table 3).

PHYSICIAN PAYMENT REFORM (PPR)

In fulfillment of a 1989 congressional directive that the Agency implement a new Medicare payment policy for physician services, HCFA worked with the Medicare carriers during FY 1991 to successfully develop all necessary calculations, software, and quality testing prior to the January 1, 1992, implementation date for a new payment policy. Physician Payment Reform (PPR) bases payment levels on relative work units that are assigned to each procedure or service.

HOSPITAL PAYMENT ACTIVITIES

HCFA published regulations to incorporate Medicare payments for capital costs into the hospital PPS. The national implementation plan for this major policy change was developed by HCFA, which provided the FIs with new operating procedures, and oversaw the development of required software.

Regulations published in 1989 required a change in Medicare's method of paying for graduate medical education costs. FIs completed the extensive audit work needed to implement this change in FY 1991.

EMPHASIS ON BENEFICIARIES

The Explanation of Medicare Benefits (EOMB) form was redesigned to improve and standardize communications with beneficiaries. EOMBs report a carrier's action on a claim to beneficiaries. The previous version had been criticized by beneficiary organizations as being too complex and hard to

understand. Beneficiary focus groups were convened to provide input on how to simplify the EOMB's language and improve the presentation of the claims information. These comments were incorporated in the EOMB's redesign.

At the same time, HCFA decentralized the process for correcting beneficiary entitlement records, which has saved over three weeks per transaction, and completed a special project with the Social Security Administration to identify and automatically enroll Qualified Medicare Beneficiaries (QMBs). These are low-income individuals with limited financial resources who qualify for State payment under Medicaid of their Medicare cost-sharing amounts.

MEDICARE AS SECONDARY PAYER (MSP)

Medicare may not pay primary benefits when payment for Medicare-covered services has been or can reasonably be expected to be made promptly under a workers' compensation law or plan of the United States or a State, or under a liability insurance policy or plan or under no-fault insurance. Also, under certain circumstances, Medicare may not pay primary benefits when payment for Medicare-covered services has been made or can reasonably be expected to be made by employer group health plans. However, medicare sometimes mistakenly pays because it is unaware that the beneficiary has alternate primary coverage. In the case of employer group health plan coverage, substantial progress was made in addressing this problem in FY 1991 through the successful implementation of a legally mandated match of Internal Revenue Service, Social Security Administration and Medicare records. By the end of FY 1991, the initial match had been performed, beneficiaries and spouses with employment-related income had been identified, and a special contractor had begun issuing surveys to identified employers for the purpose of verifying health coverage. In addition, HCFA developed plans to implement a questionnaire for verifying beneficiary health coverage at the time of initial enrollment.

MEDICAL REVIEW

A redesign of the FI medical review (MR) process was implemented during the fiscal year with emphasis placed on contractor analysis of payment data for the purpose of identifying problem providers and subjecting them to medical reviews. Plans also were developed to effect a similar review approach for Part B.

FRAUD AND ABUSE

In addition to the changes in the MR process, substantial upgrades were made in FY 1991 in contractor procedures to identify fraud and abuse. Procedures were developed to make

contractors more responsive to beneficiary allegations regarding program fraud, expedite the handling of such cases, and provide the Office of the Inspector General with better developed cases.

DURABLE MEDICAL EQUIPMENT (DME)

HCFA developed and began implementing a multi-pronged strategy for improving the administration of Medicare's DME benefit, which has been frequently cited as a program area subject to abuse. As the centerpiece of this effort, it was determined that DME claims processing would be consolidated into four regional carriers. In a related action, a new statutorily required fee schedule was implemented during the fiscal year for DME. It capped payment amounts on rental items and reduced the burden on providers by cutting the oxygen certification form from two pages to one.

ADVANCED USE OF TECHNOLOGY

HCFA continued to be a national leader in promoting the electronic submission of claims. Contractor cooperation was fostered in this area through the sharing of best practices, marketing plans and data analysis. A standard electronic claim and remittance notice format was implemented that could be used and understood by all parties. Procedures were developed for issuing Medicare payments through electronic direct deposits. Advanced data entry technologies were researched, such as optical character recognition (OCR), computer imaging and scannable claims forms.

MEDICARE CONTRACTOR OVERSIGHT

In FY 1991, HCFA monitored and evaluated the performance of the Medicare contractors through application of the national review system known as the Contractor Performance Evaluation Program (CPEP).

The 1991 CPEP for FIs consisted of 66 program standards grouped into eleven Part A functional areas, including claims processing, medical review, audit, reimbursement and financial management. In spite of increasing workload and tight budgets, most FIs continued to display extremely strong overall performance. As a group, FIs achieved a 97 percent performance rating; only two FIs failed to pass the CPEP. The two FIs failing to meet the standards were required by HCFA to establish corrective action plans to remedy their performance deficiencies.

The 1991 CPEP for carriers consisted of 67 program standards grouped into ten Part B functional areas. As a group, carriers displayed their strongest performance to date as their average performance rating rose to 95 percent. This was an increase of two percent over FY 1990 levels. However, seven carriers were

found to have deficiencies in one or more functional areas. They were required to establish corrective action plans.

During FY 1991, work continued on developing CPEP as a more effective evaluation tool. CPEP will be streamlined in future years and will do more to encourage contractor innovation and operating efficiencies.

OTHER OPERATIONAL HIGHLIGHTS

A unique physician identifier number (UPIN) system was developed and implemented during the fiscal year, and the UPINs were published in a directory of health care providers that was distributed in both a hard-copy and electronic format. Another action impacting physicians involved the issuance of surveys to identify physician ownership in clinical laboratories. This entailed issuing 22 manual instructions to Medicare contractors describing the required operational policy and processes.

PARTICIPATING PHYSICIANS AND MEDICAL SUPPLIERS

A record 47.6 percent of physicians (360,765) and 22.6 percent of medical suppliers (28,667) signed Medicare participating agreements for CY 1991. The rate of participation by physicians and limited license practitioners such as optometrists, podiatrists and chiropractors, has increased by 71 percent in five years. Participating physicians and suppliers always accept assignment on Medicare claims and agree to accept Medicare's approved amount for covered services as payment in full regardless of the actual charge. Services provided by participating physicians account for more than 70 percent of physicians' charges paid by Medicare. To encourage participation, Medicare payments are higher for participating physicians, their claims are processed faster than those of non-participating physicians, and their names are included in directories made available to the public.

CHAPTER V

RESEARCH, DEMONSTRATIONS, AND EVALUATIONS

HCFA's Office of Research and Demonstrations funded 88 new grants, contracts, and cooperative agreements during FY 1991. Following is a list of the projects, with awardees, under their respective program areas.

QUALITY OF CARE

Assessment and Use of Clinical Staging Systems (RAND Policy Research Center)

Implementing Findings on Volume and Quality (Brandeis University Research Center)

PHYSICIAN AND AMBULATORY CARE PAYMENT SYSTEMS

Group Volume/Intensity Standards Research (Brandeis University Research Center)

Methods for Tracking Volume/Intensity Change (Brandeis University Research Center)

Analysis of the Impact of Release of Medicare Carrier Prepayment Medical Review Screens on Physician Billings (University of Minnesota Research Center)

Psychiatric Codes and Billing Patterns (Project HOPE Research Center)

An Analysis of Vision Care Services (Project HOPE Research Center)

Allocating Practice Costs: Simulations and Other Empirical Work (University of Minnesota Research Center)

Technical Support for Medicare Fee Schedule Notice of Proposed Rule Making (Harvard School of Public Health)

A Comparison of Medicare and Canadian Physician Fee Schedules (Brandeis University Research Center)

Refining the Relative Work Component of the Medicare Fee Schedule (RAND Policy Research Center)

Medicare Fee Schedule: Report to Congress (Urban Institute)

Integrating Results of Physician Practice Cost Surveys (Brandeis University Research Center)

Effects of Changes in Reimbursement for Overpriced Procedures (RAND Policy Research Center)

Adjusting Physician Payment for Malpractice Risk (RAND Policy Research Center)

Technology Change, Medicare Volume Performance Standards, and Medicare Expenditure Growth (Project HOPE Research Center)

Efficient Volume Pricing of the Technical Component for Diagnostic Procedures (University of Minnesota Research Center)

Bundling the Lab-Handling Fee in the Office Visit Payment Rate (Brandeis University Research Center)

Inefficiencies in Physician Expenses: Implications for the Medicare Fee Schedule (Brandeis University Research Center)

Medicare Participating Heart Bypass Centers (St. Joseph's Hospital, Atlanta; The Ohio State University Hospitals, Columbus; Catherine McAuley Health System, Ann Arbor; The University Hospital, Boston)

Beneficiary Access to and Utilization of Physician Services: Developing Baseline and Followup Measures for Assessing Physician Payment Reform (Project HOPE Research Center)

Trends in Access to Physician Services (Brandeis University Research Center)

Developing a Paradigm for Descriptive Analysis of Physician Balance Billing of Medicare Beneficiaries (Robert L. Gruber, Baltimore)

Analysis of Utilization and Cost Data from Comprehensive Outpatient Rehabilitation Facilities (RAND Policy Research Center)

<u>CAPITATED PAYMENT SYSTEMS</u>

Health First Demonstration (The Medical Center of Beaver, PA, Inc.)

Quality Assurance Systems in Health Maintenance Organizations (University of Minnesota Research Center)

What Makes Successful Medicaid Health Maintenance Organizations Work? (Brandeis University Research Center)

Analysis of Implementation Issues Related to a Capitated Acute and Long-Term Care Service Delivery System (Brandeis University Research Center)

Analysis of Availability of Person-Specific Data for Medicaid Managed-Care Delivery Systems (Brandeis University Research Center)

Suitability of Grade of Membership Techniques to Correct for Selection Bias in the Social Health Maintenance Organization Evaluation (University of Minnesota School of Public Health)

Design of the Second Generation Social Health Maintenance Organization (Brandeis University Research Center)

Study of the Second Generation Social Health Maintenance Organization (University of Minnesota Research Center)

Evaluation of the United Mine Workers of America Demonstration (Abt Associates, Inc.)

HOSPITAL PAYMENT

Alternatives for Recalibrating Diagnosis-Related Group Relative Weights (RAND Policy Research Center)

Geographic Variation in Hospital Nonlabor Input Prices and Expenses (Brandeis University Research Center)

Monitoring Hospital Productivity (Brandeis University Research Center)

Assessment of Potential Refinements to the Prospective Payment System Outlier Payment Policy (RAND Policy Research Center)

Assessing Medicare Hospital Payment Levels (Brandeis University Research Center)

Evaluation of the Essential Access Community Hospital Program (Mathematica Policy Research, Inc.)

Update of the Tax Equity and Fiscal Responsibility Act Hospital Financial Status (Brandeis University Research Center)

Problems in Determining a Hospital's Level of Uncompensated Care (Project HOPE Research Center)

Examination of Alternative Approaches for Graduate Medical Education Payment through Medicare: Continuation of Prior Study (Project HOPE Research Center)

Study of Substitution of Rehabilitation for Hospital Services (Project HOPE Research Center)

Defining an Efficient Hospital (RAND Policy Research Center)

Hospital Cash Flow Statements (RAND Policy Research Center)

Standardized Payment Systems (Project HOPE Research Center)

PROGRAM EFFICIENCIES, ANALYSES, AND REFINEMENTS

Staff-Assisted Home Dialysis Demonstration (Abt Associates, Inc.)

Center Billings for Ancillary Dialysis Services (RAND Policy Research Center)

Rates of Inpatient and Outpatient Shunt Procedures for End Stage Renal Disease Beneficiaries (RAND Policy Research Center)

Medicaid Data Needs (RAND Policy Research Center)

Indexes for Adjusting Medicaid Eligibility and Matching Rates (Brandeis University Research Center)

Personal Health Risk Communication for Medicare Beneficiaries (University Park Pathology Associates, PS)

Bar-Coded Service Data Entry for Nursing Homes (DMH Associates, Inc.)

Prove the Feasibility of a Low-Cost, High-Quality Intravenous Flow Control Mechanism (IV Systems, Inc.)

A Diabetes Patient Management System (Marktech Systems, Inc.)

Feasibility Study of a Pharmaceutical Case Management Program to Control Costs and Increase Quality Outcomes of Pharmaceutical-Related Care (Mikalix and Company)

Improving the Quality of Medical Care Documentation Using Voice-Activated Word Processors - Phase II (Birch and Davis Associates, Inc.)

Expert-System Software for Quality Assessment (John Rafferty and Associates)

Expert System for Medical Review (Columbia Cascade, Inc.)

Development of New Automatic Interactions Detection Software - Phase II (Austin Data Management Associates)

Design and Validation of Decision-Support Software for the Critical Care Area (Huron Systems, Inc.)

Hypermedia-Based Medicare Beneficiary Information Support System - Phase II (Technovation Training, Inc.)

Impact of the Omnibus Budget Reconciliation Act Drug Regulations: Nursing Home Trends in Rates of Drug Use (University of Minnesota Research Center)

HEALTH CARE PREVENTION AND ACCESS

Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: A Managed-Care Demonstration Project for Low-Income Adults (Maine Department of Human Services)

Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: South Carolina Health Access Plan (South Carolina State Health and Human Services Finance Commission)

Medicaid Extension of Eligibility to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits: Extending Medicaid Coverage to Certain Low-Income Families (State of Washington Department of Social and Health Studies)

Access to Kidney Transplant Waiting List (RAND Policy Research Center)

Evaluation of the Medicaid Expansion Demonstrations (Abt Associates, Inc.)

Evaluation Design of Demonstration for Improving Access to Care for Pregnant Substance Abusers (Lewin/ICF)

Coordinating Care for Pregnant Substance Abusers Demonstration: Maryland (Maryland Department of Health and Mental Hygiene)

Coordinating Care for Pregnant Substance Abusers Demonstration: Massachusetts (Massachusetts Department of Public Welfare)

Coordinating Care for Pregnant Substance Abusers Demonstration: New York (New York State Department of Social Services)

Coordinating Care for Pregnant Substance Abusers Demonstration: South Carolina (State of South Carolina Health and Human Services Finance Commission)

Coordination Care for Pregnant Substance Abusers Demonstration: Washington (Department of Social and Health Services)

Subacute and Long-Term Care

Study of Post-Acute Care in Health Maintenance Organizations: Implications for Bundling (RAND Policy Research Center)

Analysis of Post-Acute Care Use for Selected Diagnosis-Related Groups (Brandeis University Research Center)

Quality of Care in the Program for All-Inclusive Care for the Elderly Model (University of Minnesota Research Center)

Evaluation of the Program for All-Inclusive Care for the Elderly Demonstration (Abt Associates, Inc.)

Analysis of Home Health Cost and Service Utilization Issues (University of Minnesota Research Center)

Demand for Formal and Informal Home Care among the Functionally-Impaired Elderly in the Community (Fu Associates)

Testing the Predictive Validity of Using Medicare Claims Data to Target High-Cost Patients (Brandeis University Research Center)

Evaluation of Demonstration to Provide Medicaid Coverage for Human Immunodeficiency Virus-Positive Individuals (Mathematica Policy Research, Inc.)

National Recurring Data Set Project: Ongoing National and State-by-State Data Collection and Policy/Impact Analysis on Residential Services for Persons with Developmental Disabilities (Administration on Developmental Disabilities)

Categorization of Nursing Homes and Rehabilitation Facilities (University of Minnesota Research Center)

Analysis and Comparison of State Board and Care Regulations and Their Effect on the Quality of Care in Board and Care Homes (Office of the Assistant Secretary for Planning and Evaluation)

Interaction of Medicaid and Private Long-Term Care Insurance (Brandeis University Research Center)

Use of Medicare Part A and Part B in Nursing Homes (Brandeis University Research Center)

Study of Medicare Home Health Agency Use of the Home Health "Case Management" Benefit (Project HOPE Research Center)

CHAPTER VI

REGULATIONS PUBLISHED IN FY 1991

Listed below are the various regulations affecting the Medicare and Medicaid programs published in the Federal Register during FY 1991. The date of publication appears in the column on the left and the page at which the item was printed is shown at the end of the title.

Date	Title
10/09/90	Medicare Program; Withdrawal of Coverage of Thermography (pg. 41140)
10/12/90	Medicare Program; Part A Premium for the Uninsured Aged for 1991 (pg. 41603)
10/24/90	Medicare Program; Data, Standards and Methodology Used To Establish Budgets for Fiscal Intermediaries and Carriers (pg. 42900)
10/24/90	Medicare Program; Standards Applied by Utilization and Quality Control Peer Review Organizations: Consideration of Remote Rural Location and Other Relevant Factors (pg. 42907)
11/01/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1991 Rates; Correction (pg. 46064)
11/01/90	Medicare Program; Inpatient Hospital Deductible and Hospital and Skilled Nursing Facility Coinsurance Amounts for 1991 (pg. 46104)
11/02/90	Medicare Program; Grace Period and Termination for Nonpayment of Supplementary Medical Insurance (Part B) Premiums for Insured and Uninsured Persons (pg. 46222)
11/06/90	Medicare Program; Limit on Payment for the Cost of Intraocular Lens Furnished by a Hospital on Outpatient Basis (pg. 46689)
11/06/90	Medicare Program; Offset Medicare Payments to Individuals to Collect Past-Due Obligations Arising From Breach of Scholarship and Loan Contracts(pg. 46685)
11/07/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1991 Rates (pg. 46887)

Date	Title
11/09/90	Criteria and Standards for Evaluating Intermediary and Carrier Performance; Correction (pg. 47165)
11/21/90	Medicare Program; Establishing Procedures for Transmitting Information Between Medicare Carriers and Medicare Supplemental Insurers (pg. 48694)
11/21/90	Medicaid Program; Eligibility Groups, Coverage, and Conditions of Eligibility; Legislative Changes Under the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), the Consolidated Budget Reconciliation Act, (COBRA), and the Tax Equity and Fiscal Responsibility Act (TEFRA) (pg. 48601)
11/27/90	Medicare and Medicaid Programs; Coordination and Maintenance Committee Meeting (pg. 49344)
12/07/90	Medicare Program; Proposed Additions to and Deletions From the Current List of Covered Surgical Procedures for Ambulatory Surgical Center (pg. 50590)
12/11/90	Medicare Program; Hospice Care Amendments: Medicare (pg. 50831)
12/13/90	Medicaid Program; Modification of Certain Requirements for Health Insuring Organizations (pg. 51292)
12/14/90	Medicare Program; Granting and Withdrawal of Deeming Authority to National Accreditation Organizations (pg. 51434)
12/17/90	Medicaid Program; Coordination of Medicaid with Special Supplemental Food Program for Women, Infants, and Children (WIC) (pg. 51735)
12/19/90	Medicaid Program; Eligibility Groups, Coverage and Conditions of Eligibility; Legislative Changes Under OBRA 87, COBRA, and TEFRA; Correction (pg. 52130)
12/26/90	Medicare Program; Proposed Additions to and Deletion From the Current List of Covered Surgical Procedures for Ambulatory Surgical Centers; Correction (pg. 53100)
12/26/90	Medicare Program; Payment Change for Home Dialysis (pg. 53007)

Date	Title
12/28/90	Medicare Program; Physician Performance Standard Rates of Increase for Federal FY 1991 (pg. 53356)
12/31/90	Medicare Program; Medicare Coverage of Screening Mammography (pg. 53510)
01/03/91	Medicare Program; Medicare Economic Index Update for 1991 (pg. 279)
01/07/91	Medicare Program; Legislative Changes Concerning Payment to Hospitals for Fiscal Year 1991 (pg. 562)
01/07/91	Medicare Program; Mid-Year FY 1991 Changes to the Inpatient Hospital Prospective Payment System (pg. 568)
01/08/91	Medicare Program; National Standardization of "Global Surgery" Policy (pg. 699)
01/11/91	Change to Medicare Secondary Payer (MSP) Provisions (pg. 1200)
01/22/91	Medicare Program; Payment to Federally Funded Health Facilities (pg. 2138)
02/05/91	Medicare Program; Medicare Coverage of Screening Mammography; Correction (pg. 4675)
02/06/91	Medicare Program; Quarterly Listing of Program Issuances and Coverage Decisions (pg. 4830)
02/21/91	Medicaid Program; Drug Rebate Agreement (pg. 7049)
02/27/91	Medicare Program; Withdrawal of Coverage of Extracranial-Intracranial Arterial Bypass Surgery for the Treatment or Prevention of Stroke (pg. 8206)
02/27/91	Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rates Beginning January 1, 1991 (pg. 8208)
02/28/91	Prospective Payment System for Inpatient hospital Capital-Related Costs (pg. 8476)
03/01/91	Medicare and Medicaid Program; OBRA '87 Conforming Amendments (pg. 8832)

Date	Title
03/05/91	Medicare Program; Quarterly Listing of Program Issuances and Coverage Decisions (pg. 9251)
03/07/91	Medicare Program; Mid-Year FY 1991 Changes to the Inpatient Hospital Prospective Payment System; Correction (pg. 9633)
03/13/91	Medicaid Program; Modification of Certain Requirements for Health Insuring Organizations (pg. 10515)
03/14/91	Medicaid Program; Eligibility Groups, Coverage, and Conditions of Eligibility; Legislative Changes Under OBRA 87, COBRA, and TEFRA (pg. 10807)
03/14/91	Medicaid; Eligibility of Aliens for Medicaid (pg. 10806)
03/27/91	Medicare Program; Peer Review Organization Contracts: Solicitation of Statements of Interest from In-State Organizations (DE, KY, NE, NV, SC, WY) (pg. 12736)
03/28/91	Medicare Program; Schedule of Limits on Home Health Agency Costs Per Visit for Cost Reporting Periods Beginning on or After July 1, 1989 (pg.12934)
04/01/91	Medicare Program; Schedule of Limits for Skilled Nursing Facility Inpatient Routine Service Costs (pg. 13317)
04/02/91	Medicare and Laboratory Certification Programs; Enforcement Procedures for Laboratories (pg. 13430)
04/09/91	Medicare Program; Schedule of Limits on Home Health Agency Costs Per Visit for Cost Reporting Periods Beginning on or After July 1, 1989; Correction (pg.14424)
04/12/91	Medicare Program; Criteria for Medicare Coverage of Adult Liver Transplants; Notice (pg. 15006)
04/15/91	Prospective Payment System for Inpatient Hospital Capital-Related Costs-Optional Computation Sheet and Computer Program (pg. 15060)

Date	Title
04/15/91	Medicare Program; Quarterly Listing of Program Issuances (pg.15083)
04/25/91	Medicare Program; Prospective Payment System for Inpatient Hospital Capital-Related Costs - Extension of Comment Period (pg. 19071)
04/26/91	Medicare Program; Prospective Payment System for Inpatient Hospital Capital-Related Costs; Correction (pg. 19335)
04/26/91	Medicare and Medicaid Programs Coordination and Maintenance Committee Meeting (pg. 19366)
04/30/91	Medicare Program; Withdrawal of Coverage of Certain Investigational Intraocular Lenses (pg. 19874)
05/01/91	Medicare Program; Advisory Committee on Medicare-Physician Relationship; Meetings (pg. 20010)
05/13/91	Medicare Program; Schedule of Limits for Skilled Nursing Facility Inpatient Routine Service Costs; Correction (pg. 22053)
05/14/91	Medicare Program; Criteria and Standards for Evaluating Common Working File Hosts (pg. 22177)
05/22/91	Medicare Programs; Quarterly Listing of Program Issuances (pg. 23619)
05/28/91	Medicaid Program; Eligibility Groups, Coverage, and Conditions of Eligibility; Legislative Changes Under OBRA '87, COBRA, and TEFRA (pg. 24010)
05/31/91	Medicare Program; Geographic Designation for Home Health Agency Branch Offices (pg. 24823)
06/03/91	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1992 Rates (pg. 25178)
06/04/91	Medicare Program; Medicare Geographic Classification Review Board-Procedures and Criteria (pg. 25458)
06/05/91	Medicare Program; Fee Schedule for Physician' Services (pg. 25792)

Date	Title
06/06/91	Medicare and Medicaid Programs; Health Care Financing Research and Demonstration Cooperative Agreements and Grants for FY 1991 (pg. 26120)
06/12/91	Medicare Program; Payment for Hospice Care (pg. 26916)
06/20/91	Medicare Program; Aggregation of Medicare Claims and Administrative Appeals and Judicial Review (pg. 28353)
06/21/91	Medicare Program; Conditions of Coverage for Organ Procurement Organizations (pg. 28513)
06/26/91	Medicare Program; HMO Qualification Determinations and Compliance Actions (pg. 20248)
06/28/91	Medicare Program; Allowing Certifications and Recertifications by Nurse Practitioners and Clinical Nurse Specialists for Certain Services (pg. 29609)
06/28/91	Medicaid Program; Medicaid Management Information System (MMIS) Performance Review: Notification Procedures for Changes in Requirements, Performance Standards, and Reapproval Conditions (pg. 29612)
07/01/91	Medicare Program; Peer Review Organization Contracts: Solicitation of Statements of Interest From In-State Organizations (AK, ID, ME, VT, DC) (pg. 29967)
07/05/91	Medicaid Program; Correction and Reduction Plans for Intermediate Care Facilities for the Mentally Retarded (pg. 30696)
07/05/91	Medicare Program; Quarterly Listing of Program Issuance and Coverage Decisions
07/05/91	Health Maintenance Organizations; Conforming Health Maintenance Organization Rules to Statutory Requirements (pg. 30723)
07/10/91	Medicare Program; Changes Concerning Interest Rates Charged on Overpayments and Underpayments (pg. 31332)

Date	Title
07/11/91	Medicare Program; Revised Procedures for Paying Claims From Providers of Services (pg. 31666)
07/11/91	Health Maintenance Organizations; Group Specific Ratings (pg. 31597)
07/12/91	Medicare Program; Medicare Secondary Payer Data Match (pg. 3192)
07/16/91	Medicare Program; Establishment of the Practicing Physicians Advisory Council and Request for Nominations for Members (pg. 32437)
07/18/91	Medicare Program; Home Health Agencies: Conditions of Participation (pg. 32967)
07/23/91	Medicare and Medicaid Programs; Coordination and Maintenance Committee Meeting (pg. 33762)
07/30/91	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1992 Rates (pg. 36030)
08/02/91	Medicare and Medicaid Programs; Survey and Enforcement Requirements and Alternative Sanctions for Home Health Agencies (pg. 37054)
08/12/91	Medicare and Medicaid; Eligibility for Premium Hospital Insurance; State Buy-in Agreements (pg. 38074)
08/13/91	Health Maintenance Organizations; Group Specific Ratings (pg. 38485)
08/19/91	Medicare Program; Uniform Electronic Cost Reporting System for Hospitals (pg. 41110)
08/22/91	Medicare Program; Changes Concerning Interest Rates Charged on Overpayments and Underpayments (pg. 41726)
08/28/91	Medicare Program; Meetings of the Advisory Committee on Medicare Physician Relationships (pg. 42628)
08/30/91	Prospective Payment System for Inpatient Hospital Capital-Related Costs (pg. 43358)

Date	Title
08/30/91	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1992 Rates (pg. 43196)
09/04/91	Medicare Program; Coverage of Erythropoietin (EPO) Used by Competent Home Dialysis Patients (pg. 43706)
09/04/91	Medicare Program; Peer Review Organizations: Revised Scopes of Work for Delaware, Missouri, Montana, Nebraska, New Jersey, Nevada, Oklahoma, Rhode Island, South Carolina, Washington, Wyoming (pg. 43790)
09/05/91	Medicare and Medicaid Programs; Recognition of the Community Health Accreditation Program Standards for Home Care Organizations (pg. 43929)
09/09/91	Medicare Program; Revision of the Medicare Economic Index (pg. 45926)
09/12/91	Medicaid Program; State Share of Financial Participation (pg. 46380)
09/13/91	Medicare Program; Review of Information Collection and Record Keeping Requirements for Providers of Outpatient Physical Therapy and/or Speech Pathology Services (pg. 46559)
09/13/91	Medicare Program; Explanation of Enrollee Rights and Other Provisions Applicable to Health Maintenance Organizations and Competitive Medical Plans (pg. 46562)
09/17/91	Medicare Program; Data, Standards and Methodology Used to Establish Budgets for Fiscal Intermediaries and Carriers (pg. 47096)
09/20/91	Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance (pg. 47758)
09/20/91	Medicare Program; Conditional Designation of States in Which Medicare SELECT Insurance Policies May Be Issued (pg. 47763)
09/26/91	Medicare and Medicaid; Requirements for Long Term Care Facilities (pg. 48826)

Date	Title
09/24/91	Medicare Program; Grace Period and Termination for Nonpayment of Supplementary Medical Insurance (Part B) Premiums for Insured and Uninsured Persons (pg. 48110)
09/24/91	Medicaid Program; Community Supported Living Arrangements Services (pg. 48112)
09/26/91	Medicare and Medicaid Programs; Nurse Aide Training and Competency Evaluation Programs (pg. 48880)
09/27/91	Medicare Program; Medicare Coverage of Home Health Services, Medicare Conditions of Participation, and Home Health Aide Supervision (pg. 49154)
09/27/91	Medicaid Program; Correction and Reduction Plans for Intermediate Care Facilities for the Mentally Retarded (pg. 49147)

CHAPTER VII

REPORTS AND PUBLICATIONS

INTRODUCTION

HCFA publishes a variety of reports and publications dealing with the Medicare program. Except where noted, single copies of the beneficiary publications listed in this section are usually available from local Social Security Administration offices during the year of issuance or by writing to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 403-B Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Placement on the mailing list for notification of all research and demonstration (R&D) reports as they are published, and single complimentary copies of publications, with the exception of the HCF Review, are available by written request from:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Executive Secretariat
Room 2230 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207

Beneficiary Publications

The Medicare 1991 Handbook (HCFA-10050 1991). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (HCFA 10128, 1991). Booklet describing Medicare coverage for end stage kidney disease patients.

Hospice Benefits Under Medicare (HCFA 02154, 1991). A pamphlet describing the special rules of coverage for care in a hospice program.

Guide to Health Insurance for People with Medicare (HCFA 02110, 1991). A consumer-oriented pamphlet for Medicare beneficiaries that discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare, and what to look for when shopping for private health insurance.

Guide to Choosing a Nursing Home (HCFA 02174, 1991). Consumer booklet explaining what to look for when selecting a nursing home for you or someone else.

Medicare and Employer Health Plans (HCFA 02150, 1991). This pamphlet explains the law which requires employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan that they offer to their younger employees.

Medicare and Coordinated Care Plans (HCFA 02195, 1991). Leaflet describing Medicare benefits available through health maintenance organizations and other prepayment plans.

Medicare Q & A (HCFA 02172, 1991) A booklet with answers to 60 commonly asked questions about Medicare.

Your Hospital Stay Under Medicare's Prospective Payment System (PPS) (HCFA 02163, 1989). A pamphlet describing the PPS, Diagnosis Related Groups and Peer Review Organizations.

Medicare Coverage for Second Surgical Opinions (HCFA 02173, 1991). A brochure addressing the advisability of seeking a second medical opinion before agreeing to any non-emergency surgery. It outlines questions a beneficiary should ask, when to get a second opinion, how to find a specialist to give a second opinion, and how to pay for a second opinion.

Medicare Secondary Payer (HCFA 02193, 1991). Booklet for employers explaining how Medicare is secondary payer for Medicare-eligible employees who are covered by employer health plans.

HCFA also acquired and distributed during 1991 a number of Medicare-related booklets published by commercial publishers in cartoon format for audiences with low literacy levels. These booklets were:

Medicare and You (Unnumbered, 1991). Cartoon booklet explaining what Medicare is, what it covers and pays, and how to qualify for Medicare.

Medicare and Medicaid (There is a Difference!) (Unnumbered, 1991). Cartoon booklet explaining the difference between Medicare and Medicaid.

About Advance Medical Directives (HCFA 04021)

Skilled Nursing Facilities Under Medicare (HCFA 04024)

About Home Health Care Under Medicare (HCFA 04025)

About Hospice Under Medicare (HCFA) 04026)

Reports

Financing Health Care for People with AIDS (HCFA 02193, 1990). Booklet describing Medicare and Medicaid benefits paid for people with Acquired Immune Deficiency Syndrome (AIDS), including funds paid and number of persons covered.

Medicare Hospital Mortality Information (HCFA 00719 through 00744, 1991). The fourth annual report of hospital mortality rates for Medicare patients at 6,000 acute care hospitals for the years 1987 through 1988. The report comprises 24 volumes and a technical supplement.

National Listing of Medicare Providers Furnishing Kidney Dialysis and Transplant Services (HCFA 03318). Self-explanatory.

A series of publications covering research and demonstration activities and providing statistical information on the Medicare and Medicaid programs were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals. These are:

National Medical Care Utilization and Expenditure Survey Reports. Reports on the survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families, and the sources and costs of services.

Health Care Financing Special Reports. Report on single themes, providing comprehensive coverage of an important issue in health care financing.

Status Report: Research and Demonstrations in Health Care Financing. Provide basic information in a brief format on the approximately 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

Health Care Financing Project Reports. Include brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and include information on obtaining related publications.

Health Care Financing Review (Quarterly Journal Plus Annual Supplement). HCFA's quarterly research journal, reports findings related to health care financing and delivery. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects. The HCF Review is available on a subscription basis ($13.00 per year) from

the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Additional information on the research publications program and the availability of various reports may be obtained from the ORD Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Final reports from completed extramural projects funded by HCFA are available for a fee by writing or phoning:

National Technical Information Services (NTIS)
Document Sales
5285 Port Royal Road
Springfield, Virginia 22161
Telephone (703) 487-4650 (Document Sales)
(703) 487-5600 (General Information)

CHAPTER VIII

REPORT ON MEDICARE VALIDATION SURVEYS OF HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JOINT COMMISSION) Fiscal Year 1991

INTRODUCTION/STATUTORY BACKGROUND

Section 1875 of the Social Security Act (the Act) requires the Secretary of DHHS to validate the accreditation process of the Joint Commission on a continuous basis. The purpose of the validation program is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the Medicare requirements as described in section 1865 of the Act. This section also requires the Secretary to submit an annual report to Congress on the findings of the validation process.

Each year, HCFA selects a statistical sample from the approximately 5,200 accredited hospitals for validation surveys. Validation surveys are also conducted in response to substantial allegations of the existence of a significant deficiency or deficiencies which would, if present, adversely affect the health and safety of patients. Validation surveys are conducted by the Medicare State survey agencies (SAs) as authorized by section 1864(c) of the Act. During CY 1991, the SAs conducted 230 sample validation surveys and investigated 1,057 complaints from which 150 full allegation surveys were conducted. These numbers do not include investigations of alleged violations of section 1867 of the Act (Examination and Treatment for Emergency Medical Conditions and Women in Labor). HCFA moved from a fiscal year analysis to a calendar year analysis beginning with the 1991 Report on Medicare Validation Surveys because the Joint Commission changes various standards in its Accreditation Manual for Hospitals each year, and the new standards are effective beginning on January 1 of each year.

ACCREDITATION PROCESS

The Joint Commission accreditation process is described in detail in section B of the 1990 Report on Medicare Validation Surveys. In CY 1991, the Joint Commission made accreditation decisions for 1,695 hospitals. This number includes decisions on some hospitals that had accreditation surveys completed the latter part of CY 1990.

VALIDATION AND ALLEGATION PROCESS

The Medicare survey process, selection basis and evaluation

methodology for validation and allegation surveys is described in detail in the 1990 Report on Medicare Validation Surveys. To evaluate the data, HCFA and the Joint Commission developed an extensive and detailed crosswalk which assigns a Federal data tag to each Joint Commission standard that is comparable to a Federal requirement. The crosswalk must be revised each year to complete the analysis.

FY 1991 ANALYSIS

At the time this report was prepared for submission, Joint Commission material was not available because the data must be converted into Medicare hospital regulation data tags via the automated crosswalk. The 1991 crosswalk is almost complete and will soon be loaded into the Joint Commission computer system. This will allow Joint Commission deficiency findings to be equated to Medicare deficiency findings so that an analysis can be completed. This analysis will be included with the FY 1992 report.

For the CY 1991 reporting period, the SAs conducted 230 sample validation surveys. Of the 230 sample validation surveys, 180 hospitals had surveys conducted within 60 days of the Joint Commission survey, 33 hospitals had surveys conducted 18 months into the Joint Commission accreditation cycle, and 17 hospitals had surveys after the Joint Commission gave the hospitals conditional accreditation decisions.

Approximately 15.5 percent of the hospitals (28 of 180 hospitals) which had a validation survey conducted within 60 days of the Joint Commission survey failed to comply with the Medicare CoPs and were placed under SA monitoring. Approximately 27.3 percent of the hospitals (9 of 33 hospitals) which had a validation survey conducted 18 months into the Joint Commission accreditation cycle failed to comply with the Medicare CoPs and were placed under SA monitoring.

Approximately 5.9 percent of the hospitals (1 of 17 hospitals) which had a survey conducted by the SA based on a conditional accreditation decision by the Joint Commission failed to comply with the Medicare CoPs and were placed under SA monitoring.

For the hospitals with SA surveys conducted within 60 days of the Joint Commission survey, the percentage of hospitals found out-of-compliance at the condition level decreased from FY 1990 to CY 1991 (25.8 percent to 15.5 percent). This is much less than all previous report periods (1974-1990) where 45 percent of the hospitals were found out-of-compliance at the condition level.

None of the hospitals found out-of-compliance with the CoPs were terminated from participation in the Medicare program. They

were all able to correct their deficiencies prior to the termination date.

For the 180 surveys conducted within 60 days of the Joint Commission survey, the conditions most frequently cited by the SAs in CY 1991 were Physical Environment (14 hospitals/ 7.7 percent), Quality Assurance (7 hospitals/3.9 percent), and Infection Control (5 hospitals/2.8 percent). For the 33 surveys conducted 18 months into the hospitals' Joint Commission accreditation cycle, the conditions most frequently cited by the SAs in CY 1991 were Physical Environment (6 hospitals/18.2 percent) and Infection Control (2 hospitals/ 6.1 percent). For the 17 surveys conducted at Joint Commission conditionally accredited hospitals, only one hospital in CY 1991 had a serious deficiency and this deficiency was with the Life Safety Code (LSC) (1 hospital/5.8 percent).

During CY 1991, there were 150 full surveys conducted based on complaints. Of the hospitals surveyed as the result of complaints, 16 percent were not in compliance with one or more conditions of participation as compared to 5 percent from the last report period. Results of investigations into allegations showed that in the hospitals placed under SA surveillance, the most frequently occurring deficient conditions were Quality Assurance (8 hospitals), Medical Staff (6 hospitals) and Infection Control (6 hospitals).

DISCUSSION

Until HCFA receives the data from the Joint Commission, a comparative analysis of survey findings cannot be completed. HCFA did note that for SA surveys conducted within 60 days of the Joint Commission survey, there is a continuing trend of increased compliance at the condition level. It was also noted that this is the first report period that includes a sample of hospitals 18 months into their respective accreditation cycles. Data from the SA surveys on these hospitals show 27.3 percent were out-of-compliance at the condition level. However, this finding may not be statistically significant since only 33 hospitals had surveys half way into their accreditation cycles. For surveys conducted on hospitals receiving conditional accreditation decisions, the SA surveys revealed that only one of 17 hospitals had a significant problem, and that was in the LSC. For these surveys, the facilities were able to make timely corrections in the areas the Joint Commission identified as deficient.

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